Supreme Court, U.S.
FILED
JAN 5 2000
CLERK

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No. 99-883

In The

Supreme Court of the United States

SCOTT BRADLEY; MARY BRAVO; ROBERT DONALDSON; PIMA COUNTY, ARIZONA, a body politic,

Petitioners,

v.

JOHN H. KELLY, in his capacity as Director of Arizona Health Care Cost Containment System; and THE STATE OF ARIZONA,

Respondents.

On Petition For Writ Of Certiorari To The Court Of Appeals, State Of Arizona, Division One

PETITIONERS' REPLY TO BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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REPLY TO RESPONDENTS' STATEMENT OF THE CASE

Respondents interjected argument into their statement of the case, therefore Petitioner must respond. The issues raised in this case are anything but "insular" or just about "money" as Respondents assert.

The State of Arizona has played fast and loose with the notice and hearing requirements of the Constitution and of the federal statutes and regulations governing Medicaid. The State failed to give the required notice of termination of benefits and right to appeal to Bradley and Donaldson. The State failed to treat similarly situated Medicaid recipients the same. These are not insular issues. They are all encompassing issues of importance to the governance of each state's Medicaid system. These are issues of national import.

REPLY TO ARGUMENT

A. Reply to Reasons for Denying Petition

The importance of this case is that if it is considered and decided in favor of Petitioners, it will provide guidance to Arizona and all other states on what must be done by the Medicaid agency when medical recipients' benefits are terminated. It will demonstrate that the important right of notice and right to a hearing each have serious meaning and must be followed.

It is also of national significance to instruct all of the states precisely what the scope and significance is of the

requirement to treat all similarly situated Medicare recipients who need organ transplants the same.

These issues are of first impression and of great importance. These are truly significant federal questions concerning the frequently litigated federal Medicaid law which need to be decided.

B. Reply to Alleged Misstatements of Fact and Law

Introduction

Respondents do themselves, this Court, Petitioners and counsel for Petitioner a serious disservice when they allege misrepresentations on the part of Petitioner which did not occur. This is a futile attempt to create factual disputes that do not exist or an attempt to muddy a record that is very clear. The record in this case supports all of Petitioners' contentions clearly and unequivocally.

Moreover, these shibboleths constructed by Respondents are irrelevant to the two central issues in this case. It is AHCCCS who must give the notice of termination of medical benefits and notice of the rights to appeal such termination. It is not the duty of the Social Security Administration. It is also AHCCCS who must treat similarly situated persons the same.

1. Petitioners do not misstate by implication that the law requires a Medicaid agency such as AHCCCS to find other ways to continue eligibility for beneficiaries whose Medicaid eligibility has been terminated. Petitioners directly contend that such is true. That is the very thrust of R9-22-341 (see App. 54), the AHCCCS rule that

requires a re-determination of eligibility. If it is not the Medicaid agencies duty to assist its ill and disabled beneficiaries in every manner of gaining legitimate eligibility, who in the world would be responsible?

2. Petitioners do not insist that a Medicaid agency such as AHCCCS make eligibility determinations left to other agencies.[1] Petitioners do insist however that where there are dual responsibilities, the agencies are required to cooperate. (See 42 CFR 431.243, App. 62.) And, it is not the duty of the Medicaid recipient to bring this about. It is the duty of the state Medicaid agency (AHCCCS) to have the agency (Commissioner of SSA) that is responsible for the eligibility determination (qualified severely disabled person) to participate in an eligibility hearing. If the foregoing were not true, there could never be a determination made that a person fits that category for ongoing Medicaid benefits as a qualified severely disabled person. The law cannot operate in a vacuum.

3. The issue of whether organ transplants are a required service for those Medicaid recipients who are categorically eligible is an issue which Respondents themselves have introduced. Respondents have argued that it is proper to provide transplants to categorically eligible persons, but not to MN/MI eligible persons because the similarly situated requirements of the federal law only applies to the categorically eligible. They argue

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[1] However, by agreement the Medicaid agency can pass on eligibility determinations to others or agree to make eligibility determinations that are the duty of the SSA among other agencies. See App. 131 for the agreement between AHCCCS and the SSA.

they have to provide transplant services to that group but do not have to provide transplant services to the MN/MI group. Respondents now argue this is not an issue in this case and is not raised by the record. This is preposterous. It is raised by the record, and the Respondents now find themselves on the wrong side of the issue, so rather than attempt a cogent argument against it, they try to make it go away. Clearly, organ transplants are not a mandated coverage.

C. Reply to Allegation that Bradley and Donaldson Did Receive Notice of Their Appeal Rights.

Respondents quote at length a notice from the SSA that advises Bradley and Donaldson of the termination of their SSI benefit. AHCCCS apparently wants this Court to believe that notice advises the recipient of the termination of their AHCCCS Medicaid benefits the right to appeal that termination. It does not. Respondents also want this Court to believe that the SSI notice informs the recipient of the right to appeal the termination of the Medicaid benefits to AHCCCS. It does not. The SSI notice only advises the recipient of the termination of the SSI benefits and the right to appeal the termination of the SSI benefits to the SSA, which is not something Bradley or Donaldson would have wanted to do because their SSI had been replaced by SSD payments.

The lack of notice and hearing which is the focus here is the failure of AHCCCS to follow the federal law, or for that matter its own regulation which requires a written notice of termination advising of the right to appeal to be sent by AHCCCS.

Respondents' argument that the SSA notice of termination somehow takes care of the duty of AHCCCS and other Medicaid agencies to give appropriate and adequate notice of termination of Medicaid benefits and the right to appeal such termination demonstrates better than anything Petitioners can say precisely why this Court must intercede. It is precisely this attitude of the state passing the buck to the federal agencies that must be addressed by this Court.

Arizona, and undoubtedly other states as well, reflects the all too prevalent social attitude of "it's not my job, it's the other guy's job". Here, the State of Arizona, through its AHCCCS Medicaid plan, has demonstrated a history of playing fast and loose with the due process rights of its Medicare recipients.[2] Its attitude, regrettably, is that the SSA will take care of it. AHCCCS says, "it's not our job".

Their attitude flies in the face of due process requirements and the standard set by Congress and the statutes and regulations of the State of Arizona for the treatment of terminated Medicaid recipients.

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[2] The federal cases directly concerning AHCCCS' past failures to give proper notice are cited on page 11 of the Petition.

D. Reply to the Argument That the Court of Appeals Properly Found Bravo Not "Similarly Situated" to Categorically Eligible Recipients.

The Respondents apparently concede that once a state determines to provide medical care that is not a mandatory coverage, the state must do so in a manner that fully complies with federal regulations and statutory law. If this is true, Respondents have no basis for stating that § 1396b(i) applies only to categorically eligible persons and not MN/MI eligible persons. To justify their position, the Respondents simply say that § 1396b(i) does not apply to the MN/MI eligible. They cite no regulation, no statute, no interpretation and no statement of legislative intent. Fortunately, Respondents have no authority to proclaim what was intended by Congress. The plain meaning of § 1396b(i) is that once a state determines to give the non-mandatory coverage of life saving organ transplants, it must provide them to eligible Medicaid recipients regardless of whether that recipient is labeled categorically eligible or MN/MI eligible so long as they are similarly situated to others needing the same type of organ transplant.

The Respondents make the following statement in their brief in opposition:

"The federal government provides no funding for the services provided to the state's MN/MI population." (Emphasis in original; Respondents' brief page 17, paragraph 2). The Respondents are not being candid. The federal regulations allow funding to the states in many respects for the medically needy. Medically Needy (MN) is defined as those persons such as Bradley, Donaldson

and Bravo who became eligible by spending down. (42 CFR 435.4, see App. 143.)

Various sections of the code of federal regulations specify the many ways in which the state receives funds, referred to as federal financial participation (FFP) for services to the medically needy. (See 42 CFR 435.1000, 1001, 1002, 1003, 1004, 1005, 1006 and 1007, App. 143-149.)

CONCLUSION

This case seriously merits consideration by this Court. State Medicaid agencies need guidance for their roles in giving proper termination and right to hearing notices. The agencies need to have this Court precisely delineate the minimum that is expected to satisfy federal law benefiting Medicaid eligible recipients, particularly where as it was here that the question of having or not having the benefits is the difference between life and death.

States need to know that MN/MI eligible persons are not the stepchildren of the Medicaid system where life saving organ transplants are concerned. This Court needs to clarify that they are indeed similarly situated to the categorically eligible. This Court needs to address this issue so that the working poor of this nation will be treated at least as well as those who have never worked, especially where the decision to terminate benefits can be a death sentence.

Respectfully submitted,

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SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED
(Agreement with the State Pursuant to Section 1634 of the Social Security Act)

AGREEMENT

Between

The
Commissioner of Social Security

and

The State of Arizona

The Commissioner of Social Security, hereinafter referred to as the Commissioner, and the State of Arizona, hereinafter referred to as the State, pursuant to section 1634 of the Social Security Act (providing for Federal determinations of eligibility for medical assistance in the case of aged, blind, or disabled individuals who are applicants for or recipients of Supplemental Security Income benefits and/or federally-administered State supplementary payments) hereby agree to the following:

Article I

DEFINITIONS

For purposes of this Agreement –

A. The term "Commissioner" means the Commissioner of Social Security or his or her designee(s).

B. The term "State" means the State of Arizona, including any subdivision thereof, acting through the Arizona Health Care and Cost Containment System (AHCCCS).

C. The term "Act" means the Social Security Act.

D. The term "benefits under title XVI" means Supplemental Security Income payments from Federal funds made pursuant to sections 1611(b) and 1619(a) of the Act, as well as optional State supplementary payments made by the Commissioner with State funds on behalf of the State pursuant to an agreement entered into under section 1616(a) of the Act, and mandatory State supplementary payments made by the Commissioner with State funds on behalf of the State pursuant to an agreement entered into under section 212(b) of Public Law (P.L.) 93-66. Individuals with special supplemental security income eligibility status pursuant to section 1619(b) of the Act shall be considered to be receiving benefits under title XVI.

E. The term "supplemental security income program" means the Federal program of Supplemental Security Income for the Aged, Blind, and Disabled established by section 301 of the Social Security Amendments of 1972, P.L. 92-603, and subsequent amendments, and codified under title XVI of the Act.

F. The term "Medicaid" means medical assistance provided by the State under the State plan approved under title XIX of the Act.

G. The term "regulations" means those regulations promulgated by the Commissioner in accordance with the Administrative Procedure Act, 5 U.S.C. 551 et. seq.

H. The acronym "HCFA" refers to the Health Care Financing Administration in the United States Department of Health and Human Services and to its employees.

I. The acronym "SSA" refers to the Social Security Administration and to its employees.

J. The acronym "BENDEX" refers to the Beneficiary and Earnings Data Exchange. The BENDEX is an electronic data exchange system containing information about benefits under titles II and XVIII of the Act. BENDEX data are supplied to the State under the terms of an agreement between SSA and each State.

K. The acronym "SDX" refers to the State Data Exchange. The SDX is an electronic data exchange system containing information about benefits under title XVI. Also, in States which have completed agreements with SSA providing for Federal determinations of eligibility for medical assistance in the case of aged, blind, or disabled individuals who are applicants for or recipients of Supplemental Security Income benefits and/or federally-administered State supplementary payments, SDX records contain information about categorical eligibility for medical assistance under title XIX of the Act. SDX data are supplied to the State under the terms of an agreement between SSA and each State.

Article II

FUNCTIONS TO BE PERFORMED BY THE COMMISSIONER

The Commissioner shall:

A. Make determinations (including redeterminations) of Medicaid eligibility on behalf of the State with respect to individuals residing in the State using the criteria established under title XVI of the Act to determine eligibility for supplemental security income benefits as a disabled, blind, or aged individual. Such determinations of eligibility shall be made

only with respect to persons who have been determined to be eligible for benefits under title XVI of the Act.

B. Make redeterminations of eligibility for Medicaid as frequently as redeterminations are made with respect to eligibility for benefits under title XVI.

C. Send to the State on a timely basis information with respect to such determinations and redeterminations (and status changes related thereto) of Medicaid eligibility by means of the SDX.

D. Furnish to the State any or all of the following by means of paper or electronic media (as decided by the Commissioner):

- SDX data relevant to Medicaid eligibility supplied under the terms and conditions of the State's Agreement with the Commissioner relating to the SDX and BENDEX,
- third party payor information received with the title XVI application or at the title XVI redetermination,
- information concerning an individual's refusal to assign rights to payments for medical services to the Medicaid State agency,
- information regarding unpaid medical expenses incurred by the individual in the three months before the filing date of the title XVI application,

and other related and necessary information secured in connection with such applications in cases where the individuals are determined to be ineligible for benefits under title XVI to assist the State in carrying out its functions under its Medicaid program.

The Commissioner shall make every effort to comply with any State request made hereunder for data in

not more than 90 days from the date of receipt of such request in order for the State to carry out its responsibilities under the Medicaid program.

E. In carrying out the functions set forth in this Article, establish procedures to detect and investigate fraud or program abuse in the supplemental security income program and make prompt reports to the State on such cases. This provision shall be understood not to preclude the Commissioner from taking appropriate action where the fraud or abuse may constitute an offense committed against the United States.

F. Perform such other functions as may be required by law, regulations, or by the Commissioner and the State through a written modification of this Agreement.

Article III

FUNCTIONS TO BE PERFORMED BY THE STATE

The State shall:

A. Provide Medicaid eligibility to all individuals eligible for benefits under title XVI of the Act.

B. Provide written notification of eligibility to individuals determined to be eligible for Medicaid by the Commissioner on behalf of the State. In addition, the State shall furnish notification to individuals who have filed an application with the Commissioner whom the State determines are not eligible for Medicaid, advising them of such determination.

C. Continue to perform the functions specifically listed in Article II above, including, but not limited to, making determinations of retroactive eligibility for Medicaid, any issuance of emergency authorizations,

any outstationing [sic] of eligibility workers at providers as required, administering and operating cost-sharing systems, and issuance and control of identification cards and other notices.

D. Perform such other administrative functions as are necessary to carry out the terms of this Agreement.

Article IV

COSTS

A. As provided for in Appendix A, the State shall pay one-half of SSA's costs incurred, which are additional to the costs incurred by SSA in carrying out the requirements of title XVI of the Act, for making Medicaid determinations, collecting information for Medicaid purposes which is related to making Medicaid determinations, and providing that information to the State for the purposes of making Medicaid determinations.

B. The State shall pay the full additional cost to SSA for any statistical or other studies and any other services which SSA agrees to provide to the State which are not directly related to making Medicaid eligibility determinations.

C. If the Commissioner and the State are unable to agree on any question of performance arising under this Agreement, the State may appeal the question to the Commissioner of Social Security. The Commissioner shall, within 90 days from the receipt of such appeal, make a determination in writing with a full explanation thereof, or provide the State written notification of the reason such determination cannot be made within said 90 days, what further information or action by the parties may be required, and within what time period a determination is expected to be made. The Commissioner's determination shall be

the final decision of the Social Security Administration. Pending the determination of the Commissioner, the State and the Commissioner shall proceed diligently with the performance of this Agreement.

Nothing in this Agreement shall be construed to waive any right the State may have to seek judicial review by a court of competent jurisdiction of both findings of fact and conclusion of law contained in the Commissioner's determination, or to enforce its right under this Agreement by any available remedies. Nothing in this Agreement shall be construed as waiving the Commissioner's right to assert lack of jurisdiction with respect to any suit brought under this Agreement, or to enforce the Commissioner's right under this Agreement by any available remedies.

Article V

LIMITATION OF LIABILITY

The Commissioner shall not be responsible for any financial loss incurred by the State, whether directly or indirectly, through the use of any data furnished pursuant to this Agreement.

Article VI

CONFIDENTIAL NATURE AND LIMITATION ON USE OF INFORMATION AND RECORDS

A. The Commissioner and the State shall adopt and maintain policies and procedures to ensure that information contained in their respective records and obtained from each other or from others in carrying out their functions under this Agreement shall be

sued by them and disclosed solely as provided in section 1106 of the Act, the regulations promulgated thereunder at 20 CFR part 401, and this Article.

B. The Commissioner shall not disclose to any individual or organization any information or records received from the State pursuant to the provisions of the Agreement except as permitted by Federal Law (e.g., section 1106 of the Act, the Privacy Act, 5 U.S.C. 552a, the Freedom of Information Act, 5 U.S.C. 552, and regulations promulgated thereunder).

C. The State agrees that unless it first obtains the Commissioner's express, written approval, it will make no use or disclosure of any information or records which the Commissioner furnishes to the State from a system of records covered by the Federal Privacy Act, except for those routine uses which the Commissioner publishes in the Federal Register for that system of records.

D. The State agrees that unless the State first obtains the Commissioner's express, written approval, it will not disclose information described in section C. of this Article for a particular program purpose pursuant to a published routine use covering unspecified income or health maintenance programs.

E. If the Sate agency which receives any information or records furnished by the Commissioner (e.g., information on the SDX) pursuant to the terms of this Agreement discloses the said information or records pursuant to a routine use described in sections C. and D. of this Article, the State agency shall only provide the elements or portions thereof which are necessary to accomplish the purposes identified in that routine use. Any element or portion thereof which is not necessary to accomplish those purposes shall not be provided.

F. The State agrees that it will keep a record of disclosures which it makes under a routine use, described in section C. and D. of this Article, to any officer or employee of a nongovernment agency or a local government or a political subdivision of the State in connection with an income or health maintenance program for which that agency, subdivision or local government is solely responsible. The State further agrees to timely furnish to the Commissioner, upon request, that record of disclosures. Such record shall describe the information disclosed including the date of the disclosure, identify the persons or agencies to whom the State disclosed, and state the purpose(s) of the disclosures.

G. Nothing in this Article shall prohibit the State from disclosing information to the Commissioner or HCFA or the individual to whom the information pertains.

H. The State agrees to the following conditions regarding safeguards to protect data to be furnished by the Commissioner from unauthorized use or disclosure:

1. To limit access to the data to only those employees and officials who need it to perform their official duties in connection with this Agreement or who may otherwise receive the data under the conditions of this Article (these individuals may be employees or officials of the State, or political subdivision responsible for the State's Medicaid program under an approved Medicaid State plan under title XIX of the Act or employees or officials of HCFA);

2. To store the data in an area that is physically safe from access by unauthorized persons;

3. To store and process magnetic media in such a way that unauthorized persons cannot retrieve

the information by means of a computer, remote terminals, or other means;

4. To advise all personnel who will have access to the data of the confidential nature of the information, the safeguards required, and the criminal sanctions for noncompliance contained in Federal statutes (such as section 1106(a) of the Act), and any relevant State statutes; and

5. To permit employees of the Social Security Administration to make onsite inspections to ensure that adequate safeguards are being maintained.

Article VII

TERM OF AGREEMENT

This Agreement shall begin on October 1, 1997 and end on September 30, 1998. It will automatically be renewed for successive periods of one year unless the State or the Commissioner gives written notice not to renew at least 90 days before the end of the current period.

Article VIII

TERMINATION AND MODIFICATION OF AGREEMENT

A. The Agreement may be modified in writing at any time by mutual consent of the parties hereto.

B. The Commissioner or the State may terminate this Agreement at any time upon 120 days written notice to the other party.

C. Nothing in this Agreement shall be construed to preclude the Commissioner from terminating this Agreement in less than 120 days if the State fails to

comply materially with the terms of section A. of Article III of this Agreement and fails to cure such noncompliance, or fails to show cause why such Agreement should not be terminated within a period of 30 days (or such longer period as the Commissioner may allow) after provision by the Commissioner of notice explaining the grounds for the proposed termination.

D. This Agreement supersedes all other Agreements and Modifications to Agreements for the Commissioner to make Medicaid determinations for the State.

In witness thereof, the parties hereby execute this Agreement this 6th day of April, 1998.

The Commissioner of Social Security
By /s/ Linda S. McMahon
Linda S. McMahon
Regional Commissioner, SSA

The State of Arizona
By /s/ Michael Veit
Michael Veit
Contracts & Purchasing Administrator
Arizona Health Care Cost Containment System

I, Gina L. Relkin, certify that I am the legal counsel of the Arizona Health Care Cost Containment System, State of Arizona; that Michael Veit who signed this Agreement on behalf of the State was then Procurement Officer of the Arizona Health Care Cost Containment System of said State, and is authorized to enter into Agreements of this nature on behalf of the State and that there is authority under the laws of the State of Arizona to carry out all the

functions to be performed by the State as herein and comply with the terms of this Agreement.

/s/ Gina L. Relkin
Signature of Legal Counsel

APPENDIX A

RETROACTIVE MEDICAL EXPENSES

The Commissioner shall:

1. Require Social Security Field Offices to complete the Title XVI application question dealing with medical expenses in the 3 month retroactive period.

2. For the performance of these functions by the Commissioner, the cost will be one-half of the administrative costs incurred.

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42 C.F.R. Sec. 435.4 Definitions and use of terms.

* * *

Medically needy refers to families, children, aged, blind, or disabled individuals, and pregnant women listed under subpart D of this part who are not listed in subparts B and C of this part as categorically needy but who may be eligible for Medicaid under this part because their income and resources are within limits set by the State under its Medicaid plan (including persons whose income and resources fall within these limits after their incurred expenses for medical or remedial care are deducted) (Specific financial requirements for determining eligibility of the medically needy appear in subpart I of this part.);

* * *

Subpart K – Federal Financial Participation

Sec. 435.1000 Scope.

This subpart specifies when, and the extent to which, FFP is available in expenditures for determining eligibility and for Medicaid services to individuals determined eligible under this part, and prescribed limitations and conditions on FFP for those expenditures.

FFP in Expenditures for Determining Eligibility and Providing Services

Sec. 435.1001 FFP for administration.

(a) FFP is available in necessary administrative costs the State incurs in determining and redetermining

Medicaid eligibility and in providing Medicaid to eligible individuals.

(b) Administrative costs include any costs incident to an eye examination or medical examination to determine whether an individual is blind or disabled.

Sec. 435.1002 FFP for services.

(a) Except for the limitations and conditions specified in Secs. 435.1007 and 435.1008, FFP is available in expenditures for Medicaid services for all recipients whose coverage is required or allowed under this part.

(b) FFP is available in expenditures for services provided to recipients who were eligible for Medicaid in the month in which the medical care or services were provided except that, for recipients who establish eligibility for Medicaid by deducting incurred medical expenses from income, FFP is not available for expenses that are the recipient's liability. (See Sec. 435.914 and Sec. 436.901 of this subchapter for regulations on retroactive eligibility for Medicaid.)

[43 FR 45204, Sept. 29, 1978, as amended at 44 FR 17939, Mar. 23, 1979]

Sec. 435.1003 FFP for redeterminations.

(a) If the Social Security Administration (SSA) notifies an agency that a recipient has been determined ineligible for SSI, FFP is available in Medicaid expenditures for services to the recipient as follows:

(1) If the agency receives the SSA notice by the 10th day of the month, FFP is available under this section only through the end of the month unless the recipient requests a hearing under subpart E, part 431 of this subchapter.

(2) If the agency receives the SSA notice after the 10th day of the month, FFP is available only through the end of the following month, unless the recipient requests a hearing under subpart E, part 431 of this subchapter.

(3) If a recipient requests a hearing, FFP is available as specified in subpart E, part 431 of this subchapter.

(b) The agency must take prompt action to determine eligibility after receiving the SSA notice.

(c) When a change in Federal law affects the eligibility of substantial numbers of Medicaid recipients, the Secretary may waive the otherwise applicable FFP requirements and redetermination time limits of this section, in order to provide a reasonable time to complete such redeterminations. The Secretary will designate an additional amount of time beyond that allowed under paragraphs (a) and (b) of this section, within which FFP will be available, to perform large numbers of redeterminations arising from a change in Federal law.

[43 FR 45204, Sept. 29, 1978, as amended at 44 FR 17939, Mar. 23, 1979; 62 FR 1685, Jan. 13, 1997]

Sec. 435.1004 Recipients overcoming certain conditions of eligibility.

(a) FFP is available, as specified in paragraph (b) of this section, in expenditures for services provided to recipients who are overcoming certain eligibility conditions, including blindness, disability, continued absence or incapacity of a parent, or unemployment of a parent.

(b) FFP is available for a period not to exceed –

(1) The period during which a recipient of AFDC, SSI or an optional State supplement continues to receive cash payments while these conditions are being overcome; or

(2) For recipients eligible for Medicaid only and recipients of AFDC, SSI or an optional State supplement who do not continue to receive cash payments, the second month following the month in which the recipient's Medicaid eligibility would have been terminated.

[43 FR 45204, Sept. 29, 1978, as amended at 45 FR 24887, Apr. 11, 1980]

Limitations on FFP

Sec. 435.1005 Recipients in institutions eligible under a special income standard.

For recipients in institutions whose Medicaid eligibility is based on a special income standard established under Sec. 435.236, FFP is available in expenditures for services provided to those individuals only if their income before deductions, as determined by SSI budget methodology, does not exceed 300 percent of the SSI

benefit amount payable under section 1611(b)(1) of the Act to an individual in his own home who has no income or resources.

[58 FR 4933, Jan. 19, 1993]

Sec. 435.1006 Recipients of optional State supplements only.

FFP is available in expenditures for services provided to individuals receiving optional State supplements but not receiving SSI, if their income before deductions, as determined by SSI budget methodology, does not exceed 300 percent of the SSI benefit amount payable under section 1611(b)(1) of the Act to an individual who has no income and resources.

[45 FR 24887, Apr. 11, 1980]

Sec. 435.1007 Categorically needy, medically needy, and qualified Medicare beneficiaries.

(a) FFP is available in expenditures for covered services provided to categorically needy recipients, medically needy recipients, and qualified Medicare beneficiaries, subject to the restrictions continued in subpart K of this part and as provided in paragraphs (b) and (e) of this section. However, the restrictions listed in paragraphs (b) and (e) of this section do not apply to expenditures for medical assistance made on behalf of qualified Medicare beneficiaries under section 1905(p) of the Act; individuals receiving Medicaid as categorically needy under section 1902(a)(10)(A)(i)(I), (II), (III), (IV), (V), (VI), or (VII) and section 1902(a)(10)(A)(ii)(I), (IX), or (X) of the

Act; individuals who are eligible to receive benefits (or would be eligible for those benefits if they were not in a medical institution); and any individuals deemed to be members of the groups identified in this sentence.

(b) Except as provided in paragraphs (c) and (d) of this section, FFP is not available in State expenditures for individuals (including the medically needy) whose annual income after deductions specified in Sec. 435.831(a) and (c) does not exceed the following amounts, rounded to the next higher multiple of $100.

(1) For individuals, 133⅓ percent of the highest money payment amount most frequently made to one-person families without income and resources under the State's AFDC plan.

(2) For couples and families of two or more, 133⅓ percent of the highest money payment most frequently made under the State's AFDC plan to a family of the same size without income and resources. If the State's AFDC plan specifies a maximum family size beyond where there is no increase in benefits, the medically needy income levels for families whose size exceeds that maximum will be determined by adding an amount for each family member over the maximum size. These amounts must be reasonably related to the amounts by which the State's AFDC plan increases benefits for additional family members in families below the maximum size.

(c) In the case of a family consisting only of two individuals, both of whom are adults and at least one of whom is aged, blind, or disabled, the State of California

may use the amount of the AFDC payment most frequently made to a family of one adult and two children for purposes of computing the 133⅓ percent limitation (under the authority of section 4103 of Public Law 100-230).

(d) For purposes of paragraph (b)(1) of this section, a State that as of June 1, 1989, has in its State plan (as defined in section 2373(c)(5) of Public Law 98-369 as amended by section 9 of Public Law 100-93) an amount for individuals that was reasonably related to 133⅓ percent of the highest amount of AFDC which would ordinarily be paid to a family of two without income or resources may use an amount based upon a reasonable relationship to such an AFDC standard for a family of two.

(e) FFP is not available in expenditures for services provided to categorically needy and medically needy recipients subject to the FFP limits if their annual income, after the cash assistance income deductions are applied and before the less restrictive income deductions under Sec. 435.601(c) are applied, exceeds the 133⅓ percent limitation described under paragraphs (b), (c), and (d) of this section.

[58 FR 4933, Jan. 19, 1993]

* * *